STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING _____ B. WING _____	C 04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	**7519 WINCHESTER RD FORT WAYNE, IN 46819**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00195948 and IN00196733.

Complaint IN00195948 - Unsubstantiated, due to lack of evidence.
Complaint IN00196733 - Unsubstantiated, due to lack of evidence.

Survey Dates: April 21 & 22, 2016

Facility number: 000250
Provider number: 155359
AIM number: 100289980

Census bed type:
SNF/NF: 43
Total: 43

Census payor type:
Medicare: 3
Medicaid: 31
Other: 9
Total: 43

Sample: 4

Riverbend Health Care Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00195948 and IN00196733.

QR was completed by 99993 on 04/25/16.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE